Bureau of TennCare/Medicaid
Provider Enrollment
310 Great Circle Road
Nashville, TN 37243-1700

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
NO. 2 INDIVIDUAL APPLICATION - TENNESSEE MEDICAID PROGRAM

PLEASE FILL OUT THIS APPLICATION AS COMPLETELY AS POSSIBLE AND SIGN IN THE APPROPRIATE SPACE.

Complete Name: _____ **Title:** _____
(As Shown on License) **(M.D., D.D.S., etc.)**

Practice or Business Location Address (No P. O. Box #)		**Pay To Address** (if different from Practice or Business Location)	
Street:		**Name or D/B/A**	
City:		**Street**	
County:		**City:**	
State:		**County:**	
Zip Code:		**State:**	
Telephone #:		**Zip Code:**	
Fax Number:		**Telephone #:**	

Federal Tax No. (IRS No.): _____ **Social Security No. (req'd):** _____
Federal Medicare No.: _____ **State Medicaid No.:** _____
State License No.: _____ **Date Of Issuance:** _____
Month / Day / Year

Medical Specialty: _____
Board-Certified (Y/N): _____ **Board-Eligible (Y/N):** _____
Name of Board: _____
Certificate No.: _____ **Date of Issuance:** _____
Hospital-Affiliated (Y/N): _____ **Hospital-Based (Y/N):** _____
Name of Hospital: _____

Radiologists/Pathologists: **Do you bill for professional component only, or for both professional and technical components?**
Professional Only (Y/N): _____ **Both (Y/N):** _____

Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs Yes ___ No____. If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.

Provider's Original Signature: _____ **Date:** _____

EFFECTIVE DATE FOR OPENING/REOPENING OFFICE: _____

If you belong to a group and authorize all monies due be made payable to the group, please indicate the name and provider number of said group and sign below.

_____ _____
Group Name **TN Medicaid Group Provider No.**

Provider's Original Signature: _____ **Date:** _____

OVER

Please list the full name of every owner, with Social Security number and percent of ownership (required). If owned by corporation, please list corporate officers with same information. Use additional paper ,if necessary.

	Name	Title	SSN	% Ownership
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any) : _____

Previous Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

EFFECTIVE DATE OF CHANGE OF OWNERSHIP _____

IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.